

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COPPER BASIN			STREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 DUCKTOWN, TN 37326		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments Complaint investigation #28096, #28428, #28469, and #28809 were completed on March 30, 2012, at Life Care Center of Copper Basin. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

BMIQ11

If continuation sheet 1 of 1

[Signature]

EXECUTIVE DIRECTOR

4/12/2012

APR 13 2012